STATE OF MICHIGAN

IN THE SUPREME COURT

COVENANT MEDICAL CENTER, Plaintiff-Appellee, v STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY, a Michigan insurance corporation, Defendant-Appellant.	Supreme Court No. 152758 Court of Appeals No. 322108 Saginaw Circuit Court No. 13-020416-NF

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AMICUS CURIAE BRIEF OF MICHIGAN DEFENSE TRIAL COUNSEL

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QUESTIONS PRESENTED

1. Does the Michigan no-fault act vest a healthcare provider with rights sufficient enough to allow it to bring a civil action directly against its patient's no-fault insurer for the collection of personal protection insurance (PIP) benefits?

Amicus Curiae MDTC says "no."

2. Can an express release agreement executed by an insured operate to discharge any obligation that the insurer has to the insured's healthcare provider, notwithstanding the provisions contained in MCL 500.3112?

Amicus Curiae MDTC says "yes."

STATEMENT OF INTEREST OF *AMICUS CURIAE*

The Michigan Defense Trial Counsel ("MDTC") is a statewide association of attorneys whose practices are primarily comprised of the representation of defendants in civil litigation. The MDTC was established in 1979 with the goal of enhancing the quality of the civil litigation defense bar and promoting the interests of defense attorneys, as well as the clients they serve. The MDTC furthers its mission by providing programing and educational resources for defense lawyers in order to improve the effectiveness of advocacy for civil defendants, and further aims to promote the overall efficient administration of, and access to, justice in civil proceedings for the benefit of all Michigan civil litigants. The MDTC has been regularly invited by this Court to submit *amicus curiae* briefs on issues effecting civil litigation and has appeared before this Court on numerous occasions as an *amicus curiae*.

The MDTC maintains that the rule announced in this case by the panel below is unworkable and has greatly frustrated litigants' ability to obtain finality when settling no-fault insurance disputes. This, in turn, has increased the volume of first-party no-fault insurance litigation, which already overly burdens our state's trial courts and unnecessarily overconsumes limited judicial resources. This result is not only problematic as a matter of judicial policy and economy, but it is directly contrary to the policy goals of the Michigan no-fault act. See *Shavers v Kelley*, 402 Mich 554, 622; 267 NW2d 72 (1978) (recognizing that the no-fault insurance scheme was intended to alleviate our state court system from the "heavy burden" imposed by automobile tort litigation).

This case also calls into question the nature and propriety of so-called no-fault "provider litigation," which the MDTC maintains was the initial catalyst for the current mass of unnecessary no-fault litigation burdening our trial courts. Despite having adequate means to protect their interests in a patient's no-fault automobile insurance claim, in recent years an increasing number of healthcare providers have taken to the practice of "independently" pursuing civil litigation against their patients' insurers. Often times, these actions are brought and prosecuted by the healthcare provider despite the pendency of a separate lawsuit brought by that provider's patient, who is claiming benefits for the very same charges. This duplicative litigation, (1) is a waste of judicial resources, (2) unnecessarily increases the cost of defending no-fault insurance claims, and (3) delays the administration of, and access to, justice for clients of our State's trial courts. For these reasons, the MDTC also urges this Court to hold that a healthcare provider lacks the right to pursue a no-fault insurance claim directly in its own stead against its patient's no-fault insurance carrier.

INTRODUCTION AND OVERVIEW

The heart of the issue in this case is rather narrow and the error by the Court of Appeals panel, despite the severe effect it has had in practice, is rather clear and easily repairable by this Court. Under MCL 500.3112, payment by an insurer will not discharge that insurer's obligation if it has been notified in writing of the claim of some other person. In this case, the basis for the discharge of the claim was not "payment" by the insurer, but rather an express "release" executed by the insured. Nothing in the plain language of § 3112 proscribes the otherwise discharging effect of an express release. The panel's error was in rewriting the statute to insert the phrase, "and release" after the term "payment." When the statute is properly construed without the added phrase, "and release," plaintiff is not shielded from the discharging effect of the express release executed by the insured. Therefore, based on that release, plaintiff's claims should be dismissed.

That, however, is only part of the story and problem here. Even if the Court of Appeals' improper construction is repaired by this Court and this case is reversed on that narrow basis, § 3112 is still operable where there has been no express release or adjudication. Of course, this is how most PIP claims are handled, making it difficult, if not impossible, for an insurer to secure finality based on the payment of benefits alone.

The deep root of this problem is not simply the construction of § 3112, but rather the relatively recent advent and spread of "healthcare provider litigation." A review of the law reveals that there is no firm foundation for the proposition that a healthcare provider has a direct and independent claim against its patient's no-fault

insurer; though, the proposition and the litigation has been widely approved by the trial courts within the past five years or so. An examination of the negative effect that provider litigation has had on the no-fault system, as well as the burden it has placed on our courts, during that period of time confirms that the practice frustrates a number of the intended policies the no-fault act was intended to address. Moreover, because sufficient alternative means are available to healthcare providers for the protection of their interests, it is apparent that the practice serves little purpose, and its discontinuation will harm the healthcare industry.

Therefore, MDTC urges this Court to conclude that the law of this state does not provide an independent cause of action to a healthcare provider directly against its patient's no-fault insurer, but that the healthcare provider's claim lies exclusively against the patient to whom it provided the medical services.

STATEMENT OF FACTS AND PROCEDURAL HISTORY

Amicus MDTC relies on the statement of facts and material proceedings contained in Defendant-Appellant State Farm's Brief on Appeal.

STANDARD OF REVIEW

This Court reviews de novo motions for summary disposition brought under MCR 2.116(C)(10). *Johnson v Recca*, 492 Mich 169, 173, 821 NW2d 520 (2012), citing *Dressel v Ameribank*, 468 Mich 557, 561; 664 NW2d 151 (2003). Likewise, the proper construction and application of the no-fault act presents an issue of statutory interpretation, which, in turn, is a question of law that this Court reviews de novo. *Spectrum Health Hosps v Farm Bureau Mut Ins Co of Michigan*, 492 Mich 503, 515;

821 NW2d 117 (2012). In construing the no-fault act, the Court is called upon to apply the longstanding principles of statutory interpretation:

> The primary goal of statutory interpretation is to ascertain the legislative intent that may reasonably be inferred from the statutory language. The first step in that determination is to review the language of the statute itself. Unless statutorily defined, every word or phrase of a statute should be accorded its plain and ordinary meaning, taking into account the context in which the words are used. We may consult dictionary definitions to give words their common and ordinary meaning. When given their common and ordinary meaning, "[t]he words of a statute provide 'the most reliable evidence of its intent.... [*Spectrum Health Hosps, supra* at 515, quoting *Krohn v Home–Owners Ins Co*, 490 Mich 145, 155; 802 NW2d 281 (2011) (citations and quotation marks omitted).]

LEGAL ARGUMENT

I. MICHIGAN LAW DOES NOT VEST A HEALTHCARE PROVIDER WITH A CLAIM OR RIGHT OF ACTION AGAINST ITS PATIENT'S NO-FAULT INSURANCE CARRIER

> "There is nothing so absurd that it cannot be believed as truth if repeated often enough." – *William James*

Neither this Court nor any panel of the Court of Appeals has truly analyzed whether, and more importantly, *why*, a healthcare provider has a "claim" and right of action against its patient's no-fault insurance carrier. Nonetheless, in recent years the proposition has been continually repeated and embraced as gospel truth by lower courts and practitioners alike. As State Farm has already explained, the supposed rule is based on a fatally flawed legal foundation. And, as often as the proposition may have been repeated and characterized as "established law" over the

past ten years, this is the first time that the question has been before this Court, and is, at this point, an issue of first impression.

For the reasons cited by State Farm, and for the additional reasons addressed herein, MDTC asks this Court to conclude that a healthcare provider does not have a "claim" or direct legal cause of action against its patient's automobile no-fault insurer.

A. Nothing in the No-Fault Act Itself Vests a Healthcare Provider with a Claim or Right of Action against its Patient's No-Fault Insurer

Certainly, a healthcare provider that furnishes medical services to a person for injuries sustained in a motor vehicle accident has a "claim" and "right" to be paid for those services. That right may be founded on a legal theory of an express or implied contract between the provider and the patient, or under an equitable theory of quasi contract.[1] In turn, the person that incurs loss associated with injuries arising out of the operation, maintenance or use of a motor vehicle is vested with a right to claim PIP benefits against the applicable no-fault insurer. Neither proposition is novel or in dispute.

These are two separate theories, founded upon two different sets of rights. While a healthcare provider has certain rights and "claims" against its patient, those rights and claims are distinct from the ones the patient has against his

[1] See, gen., *In re Crisan's Estate*, 362 Mich 569; 107 NW2d 907 (1961). Indeed, because no-fault benefits are only payable to the extent that loss has been "incurred," as a universal threshold matter for any no-fault claim patient must have some legal obligation to the provider. *Proudfoot v State Farm Mut Ins Co*, 469 Mich 476; 673 NW2d 739 (2003)

insurer. Accordingly, in order for a healthcare provider to pursue an insurer, one of two propositions must be true: (1) the provider's claims against the patient are enforceable against someone other than the patient, or (2) the patient's claims against his or her insurer is enforceable by someone other than the patient. Unless one of these two propositions is true, the lines of liability remain parallel and do not cross: the provider's claim remains against the patient, and the liability for the payment of PIP benefits runs from the insurer to its insured.

While plaintiff speaks in terms of its "right to be paid" for the services, the question here is much narrower than that. The right to be paid does not necessarily equate to the right to claim PIP benefits from a patient's no-fault insurer. Of course, that more precise question is the issue presented here.

Looking first to the statute, nothing in the plain language of the no-fault act elevates a provider's general right to be paid for services rendered into a right to claim insurance benefits from its patient's insurer. Plaintiff strains to read §§ 3107 and 3157 in a way that would give a healthcare provider a direct and independent right to obtain PIP benefits from its patient's insurer. Those sections, however, do not convey the rights or sentiments that plaintiff suggests.

Plaintiff first focuses on the terms "payable" and "charges" as used in MCL 500.3107.[2] While plaintiff offers a dictionary definition of the term "payable,"[3] it

[2] Appellee's Brief on Appeal, pp. 7-8.

[3] The definition of "payable" that plaintiff offered ("to be paid; due") is a circular definition that is of no utility in ascertaining the true meaning of the statutory term, "payable". See *Thomas v Stubbs*, 218 Mich App 46, 51; 553 NW2d 634, 637 (1996) rev'd on other grounds 455 Mich 853.

does not explain how the phrase "payable for…allowable expenses consisting of all reasonable charges incurred…" vests a medical service provider with rights against an insurer. Despite what plaintiff suggests it sees, from this writer's viewing angle it appears that this language does little more than define the scope and nature of personal protection insurance benefits. The section is completely silent as *to whom* the benefits are *payable* and provides no guidance in answering the question at issue here. And, while MCL 500.3157 expressly permits a healthcare provider to "charge a reasonable amount for the products, services, and accommodations rendered," it does not permit the provider to "charge *an insurer*…" nor does it obligate a no-fault carrier to "*pay* the service provider." Plaintiff's answer that "it has a right to be paid" is not responsive to the real matter of inquiry: whether plaintiff has a direct right to collect that payment from its patient's insurer.

If, by way of its use of the terms "payable" and "charges" in §§ 3107 and 3157, the Michigan Legislature intended to vest a healthcare provider with the right to sue or otherwise pursue collection against its patient's no-fault carrier directly, it certainly chose a cryptic way of expressing that intent.

While some states have, in fact, chosen the public policy that plaintiff advocates for here, those legislators had no difficulty clearly expressing that policy choice. For example, the Hawaii automobile no-fault law is very clear about the obligations that a no-fault insurer has to a healthcare provider:

> Every personal injury protection insurer shall provide personal injury protection benefits for accidental harm as follows:

> (1) Except as otherwise provided in section 431:10C-305(d), in the case of injury arising out of a motor vehicle accident, the insurer shall pay, without regard to fault, ***to the provider of services*** on behalf of the following persons who sustain accidental harm as a result of the operation, maintenance, or use of the vehicle, an amount equal to the personal injury protection benefits as defined in section 431:10C-103.5(a) payable for expenses to that person as a result of the injury… [Haw Rev Stat Ann 431:10C-304 (emphasis added).]

If the Michigan Legislature truly intended what plaintiff suggests, it is reasonable to expect to find some expression similar to that found in the Hawaii statute. Nothing to that effect is found in the no-fault act.[4]

Plaintiff's proposed construction of MCL 500.3112 is equally as tortured and mysterious. MCL 500.3112 speaks *to whom* benefits are payable: "***to or for the benefit of an injured person***." While the phrase contemplates payment to someone other than an injured person, it does not reveal the identity or nature of *who or what* this other payee may be. Without explaining why the other payee would include a healthcare provider, plaintiff makes a large logical leap by calling this person a "*claimant,*" and vests this "claimant" with rights not otherwise

[4] While it is unrealistic to presume that the Michigan Legislature is in the habit surveying statutes form other jurisdictions in order refine the prose it adopt to express its intent, the Hawaii statute is offered as an example of the way in which the Michigan Legislature could have easily and clearly expressed what plaintiff suggests must be read into its use of the terms "payable" and "charges."

expressly provided for in that section.[5] Plaintiff's proposed construction is undisciplined and founded in presumptions that are not present in the language of the statute. Again, it is not difficult to clearly express what plaintiff suggests is implied by MCL 500.3112. This begs the question: if the Legislature wanted it so, why did it not *say* so?

While MDTC believes that State Farm's construction of § 3112 is correct, the best plaintiff can do is suggest that the section is ambiguous as to the scope and meaning of the phrase, "for the benefit of…," and as to whether the phrase was intended to vest a provider with rights of some variety. As discussed below, common law would not recognize a third party's ability to enforce contractual rights under these circumstances. Construing the statute as plaintiff argues it should be construed would abrogate the common law. However, the abrogation of common law is never to be presumed and may only be found upon a clear expression of the same. *Hoerstman Gen Contracting, Inc v Hahn*, 474 Mich 66, 74; 711 NW2d 340 (2006) (the Legislature "should speak in no uncertain terms" when it exercises its authority to modify the common law); see also *Dawe v Dr Reuven Bar-Levav & Assoc, PC*, 485 Mich 20, 28; 780 NW2d 272, 277 (2010). Therefore, even if the statute were ambiguous, this Court should not read into MCL 500.3112 a right of

[5] The section goes on to authorize application to a circuit court for any appropriate order when there is doubt about a proper payee. Interestingly, the statute extends this authority to "the insurer, the claimant or any other interested person…". While plaintiff is quick to conclude that the "claimant" designation applies to a healthcare provider, it does not explain why the healthcare provider would not better fit in the "other interested person" category. And, if the healthcare provider does not fit the "other interested person" category, who would?

action for a medical service provider that is not otherwise clearly and unambiguously conveyed in the text of the statute itself.

Accordingly, the text of the no-fault act itself does not clearly vest healthcare providers with rights and claims to proceed directly against their patient's insurers. Therefore, if such rights truly exist, they must spring from some other source.

B. Common Law and General Legal Principles Do Not Support Recognition of a Healthcare Provider's Direct and Independent Claim against it Patient's No-Fault Insurer

When stripped to its essential nature, the right to personal protection insurance benefits is founded upon the law of contracts. See, gen., *LaMothe v Auto Club Ins Assoc*, 214 Mich App 577; 543 NW2d 42 (1996). While Michigan law imposes certain mandatory terms and conditions that cannot be contracted around, the fundamental essence and nature of no-fault coverage is an insurance contract between an insurer and an insured. See *Rory v Contl Ins Co,* 473 Mich 457, 460; 703 NW2d 23 (2005). This begs the distinct question of whether a healthcare provider has the power to enforce rights under a no-fault insurance contract to which they are not a party.

1. Michigan Law Does Not Recognize a Third Party's Right to Enforce Obligations Under an Insurance Contract

By way of statute, Michigan subscribes to the modern common law view concerning whether a third party to a contract may take action to enforce it. Under MCR 600.1405,

> Any person for whose benefit a promise is made by way of contract, as hereinafter defined, has the same right to enforce said promise that he would have had if the said promise had been made directly to him as the promisee.

> (1) A promise shall be construed to have been made for the benefit of a person whenever the promisor of said promise had undertaken to give or to do or refrain from doing something directly to or for said person.

In construing this statute, this Court concluded that the Legislature recognized a distinction between "intended beneficiaries" and "incidental beneficiaries":

> As we recently said in *Brunsell v Zeeland*, 467 Mich 293, 296, 651 NW2d 388 (2002), the plain language of this statute reflects that not every person incidentally benefitted by a contractual promise has a right to sue for breach of that promise.... Thus, only intended, not incidental, third-party beneficiaries may sue for a breach of a contractual promise in their favor. *Id.* [*Schmalfeldt v N Pointe Ins Co*, 469 Mich 422, 427; 670 NW2d 651, 654 (2003).]

In *Schmalfeldt*, this Court considered whether an injured bar patron was entitled to sue an insurer for payments under a medical payment provision contained in the policy covering the bar. The Court concluded that under MCL 600.1405, the patron could only maintain that action directly against the insurer if the patron was found to be an "intended beneficiary" under the policy. The Court concluded that despite the benefit that patron could potentially gain by virtue of the insurance contract, he was only incidental beneficiary.

> The focus of the inquiry, however, should be whether North Pointe, by its agreement to cover medical expenses for bodily injuries caused by accidents, had undertaken to give or to do or refrain from doing something directly to or for Schmalfeldt pursuant to the third-party beneficiary statute, M.C.L. § 600.1405(1). Thus, as Brunsell clarifies, we must turn to the contract itself to see whether it granted Schmalfeldt third-party beneficiary status.

> We affirm the decision of the Court of Appeals because the contract contains no promise to directly benefit Schmalfeldt within the meaning of 1405. Nothing in the insurance policy specifically designates Schmalfeldt, or the class of business patrons of the insured of which he was one, as an intended third-party beneficiary of the medical benefits provision. At best, the policy recognizes the possibility of some incidental benefit to members of the public at large, but such a class is too broad to qualify for third-party status under the statute. *Brunsell, supra* at 297, 651 NW2d 388; *Koenig, supra* at 680, 597 NW2d 99.
>
> Only intended beneficiaries, not incidental beneficiaries, may enforce a contract under 1405. *Koenig, supra* at 680, 597 NW2d 99. Here, the contract primarily benefits the contracting parties because it defines and limits the circumstances under which the policy will cover medical expenses without a determination of fault. This agreement is between the contracting parties, and Schmalfeldt is only an incidental beneficiary without a right to sue for contract benefits. For this reason, North Pointe is entitled to summary disposition. The Court of Appeals judgment in favor of defendant is affirmed. MCR 7.302(G)(1). [*Schmalfeldt, surpa* at 429.]

Applying that reasoning to the no-fault context, like the bar patron, the healthcare provider is merely an incidental beneficiary. While a provider's actual economic interest may be substantial, like the bar patron in *Schmalfeldt*, the PIP coverage is there for the benefit of the injured person. After all, the name chosen by the Legislature for the coverage is "*personal* protection insurance."[6] This Court should

[6] Moreover, with few exceptions the major policy concern associated with healthcare providers is not whether they will be able to collect payment for services they performed, but rather that the insurance scheme not increase the cost of medical services. See, e.g., *AOPP v Auto Club Ins Ass'n*, 257 Mich App 365, 378; 670 NW2d 569 (2003).

hold that a healthcare provider is, at best, an incidental beneficiary without the right to directly enforce its patients' insurance policies.

2. Other Jurisdictions Reject Provider No-Fault Litigation

Almost every other jurisdiction considering the status of a healthcare provider under its patient's insurance policy has concluded that the healthcare provider is merely an incidental beneficiary not entitled to enforce rights or bring a direct cause of action against the insurer.

In 2008, the Supreme Court of Kentucky concluded that a medical provider had no standing under the Kentucky Motor Vehicle Reparations Act[7] to bring a direct action against automobile insurers. *Neurodiagnostics, Inc v Kentucky Farm Bureau Mut Ins Co*, 250 SW3d 321, 323 (Ky 2008). Over the objection of the plaintiff provider, which argued that "if medical providers are not entitled to assert claims for payment, there is little motivation for an insurance company to make prompt and proper payments," the Court examined the statute and concluded that there was no legal basis on which the medical provider could pursue an insurer directly. Instead, consistent with fundamental contract law principles, the provider was required to pursue the insured, who, in turn, could pursue his or her insurer.

> Reading KRS 304.39–241 in light of the MVRA as a whole, we conclude that a medical provider, such as LDC, is an optional payee or incidental beneficiary of the no-fault policies. And, as an incidental beneficiary, LDC has no direct right of action against the reparation obligor. If a medical provider does not receive payment from the

[7] See Kentucky Revised Statutes (KRS) 304.39–010 to 304.39–350. The Kentucky statute was adopted in 1974 and, like Michigan's act, was based largely on the Uniform Motor Vehicle Accident Reparations Act (UMVARA).

> reparation obligor, either because benefits have been exhausted (the State Farm case) or because the reparation obligor determines that the charges were neither reasonable nor medically necessary (the Farm Bureau case), then the insured is the party that is ultimately responsible for payment. And it is the insured that has the direct right of action against the reparation obligor if he or she disagrees with the way in which his or her benefits were either paid or not paid. [*Neurodiagnostics, Inc, supra* at 328.]

The Arkansas Supreme Court came to a similar conclusion when examining its automobile no-fault law

> We have repeatedly held that the presumption is that parties contract only for themselves and, thus, a contract will not be construed as having been made for the benefit of a third party unless it clearly appears that such was the intention of the parties. *Little Rock Wastewater Util v Larry Moyer Trucking, Inc*, 321 Ark 303, 902 SW2d 760 (1995); *Howell v Worth James Constr Co*, 259 Ark 627, 535 SW2d 826 (1976). If a contract is made for the benefit of a third party, then it is actionable by such third party if there is substantial evidence of a clear intention to benefit that third party. *Id.* Furthermore, "[i]t is not necessary that the person be named in the contract, and if he is otherwise sufficiently described or designated, he may be one of a class of persons if the class is sufficiently described or designated." *Little Rock Wastewater Util.*, 321 Ark. at 307, 902 S.W.2d at 763 (citing *Howell*, 259 Ark. at 630, 535 SW2d at 829). With this in mind, we now turn to the present case.
>
> In this case, Appellant was not a party to the insurance contract. The policy lists coverage of two individuals—Mr. and Mrs. Langley. Appellee is the other party to the making of that contract. The presumption is that the insurance contract was created to benefit only those parties listed. There is nothing within the contract that clearly indicates that the contract was also made for the benefit of a third party, such as Appellant. While it is true that Appellant is a member of a class of individuals—health-care providers—who would provide the services

> contemplated by the PIP policy, there is no reference to these providers within the policy itself. There is nothing to indicate that the Langleys or Appellee intended Appellant to be a third-party beneficiary. Consequently, he does not have standing to bring suit directly against Appellee for breach of contract. [*Elsner v Farmers Ins Group, Inc*, 364 Ark 393, 396; 220 SW3d 633, 635 (2005).]

In *Parrish Chiropractic Ctrs PC v Progressive Cas Ins Co*, 874 P2d 1049 (Colo.1994) (*Parrish II*) the Colorado Supreme Court held that "a private provider of chiropractic services which provided treatment to a patient insured under a No–Fault policy is not a third-party beneficiary of the No–Fault policy and thus is not entitled to recover in a direct action to enforce the terms of that policy." *Id.* at 1051. Again, that Court framed the issue in terms of the distinction between an intended and incidental beneficiary under the insurance scheme.

> A person not a party to an express contract may bring an action on the contract if the parties to the agreement intended to benefit the non-party, provided that the benefit claimed is a direct and not merely an incidental benefit of the contract. *EB Roberts Constr Co v Concrete Contractors, Inc*, 704 P2d 859, 865 (Colo.1985). While the intent to benefit the non-party need not be expressly recited in the contract, the intent must be apparent from the terms of the agreement, the surrounding circumstances, or both. Id. [*Parrish II* at 1056.][8]

In performing that analysis, the Court relied upon two findings to reach its conclusion that the doctor was not a third-party beneficiary: (1) the doctor was "only one of many health care providers" that the insured could choose from, and (2) the

[8] In this respect, Colorado's law concerning third-party beneficiaries is somewhat more liberal than the construction accorded to the third-party beneficiary statute by this Court in *Schmalfeldt*. However, even under the more liberal standard, that Court could not find that the healthcare provider was an intended beneficiary of the insurance agreement.

doctor was "not obliged under any statutory scheme to provide medical treatment to" the insured individuals. *Id.* at 1056. Thus, the court concluded that the doctor was "only an incidental beneficiary of the [insurance company's] PIP policy and, as such, [was] not entitled to recovery in a direct action to enforce the terms of that policy." *Id.* at 1056–1057.

The Hawaii Supreme Court,[9] the Superior Court of New Jersey,[10] the Supreme Court of Virginia,[11] and the Superior Court of Pennsylvania,[12] have all come to the same conclusion after construing their respective state's automobile no-fault law. When comparing those states' laws with that of Michigan, it is clear that there is nothing peculiar about either Michigan's no-fault statute or its third-party beneficiary statute that would call for a contrary conclusion in construing the statutes and legal principles at issue here.

The same issue has been addressed in the context of worker's compensation. Again, almost all courts that have reviewed the matter have concluded that despite its pecuniary interest, a healthcare provider does not have the right to pursue the

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[9] *Jou v Dai-Tokyo Royal State Ins Co*, 116 Hawai'i 159; 172 P3d 471 (2007). While the Court concluded that the provider lacked standing to enforce contractual covenants, as discussed above the Hawaii statute makes actual provision for a provider to pursue benefits under certain circumstances.

[10] *Parkway Ins Co v New Jersey Neck & Back*, 330 NJ Super 172; 748 A2d 1221 (1998)

[11] *Kelly Health Care, Inc v Prudential Ins Co of Am, Inc*, 226 Va 376; 309 SE2d 305 (1983).

[12] *Ludmer v Erie Ins Exch*, 295 Pa Super 404; 441 A2d 1295 (1982)

insurer directly for the collection of its charges. *See, e.g.*, *Chiropractor Martis v Grinnell Mut Reinsurance Co*, 388 Ill App 3d 1017; 905 NE2d 920 (2009).[13]

While plaintiff suggests that without the ability to bring an independent cause of action directly against the insurer, healthcare insurers will be unable to protect their interests and right to be paid for the services they provide to patients injured in motor vehicle accidents. However, nothing suggests that the healthcare providers in these jurisdictions have suffered loss due to the inability to file lawsuits against their patient's insurers. Rather, as the Supreme Court of Arkansas observed, the law adequately protects a provider's interests:

> If a medical provider does not receive payment from the [no-fault insurer]…then the insured is the party that is ultimately responsible for payment. And it is the insured that has the direct right of action against the [no-fault insurer] if he or she disagrees with the way in which his or her benefits were either paid or not paid. [*Neurodiagnostics, Inc, supra*, at 328.]

Not only is this approach consistent with the traditional legal principles this Court is bound to apply, but it provides sufficient protection for healthcare providers without the complications and procedural irregularities, detailed below, that so called "provider litigation" has worked on the no-fault insurance system and the courts of this state.

[13] See also, *McFadden v Liberty Mut Ins Co*, 803 F Supp 1178 (ND Miss 1992); *CNA Ins Co v Scheffey*, 828 SW2d 785 (Tex App 1992); *Furno v Citizens Ins Co of Am*, 590 NE2d 1137 (Ind Ct App 1992).

II. THE PRACTICAL EFFECT OF HEALTHCARE PROVIDER LITIGATION SUBSTANTIALLY FRUSTRATES THE EXPRESS PUBLIC POLICY GOALS OF THE MICHIGAN NO-FAULT ACT

The public policy goals behind the no-fault insurance act are no mystery and have been continually recognized since the adoption of the act in 1973. The act created a compulsory motor vehicle insurance program under which insureds may recover directly from their insurers, without regard to fault, for qualifying economic losses arising from motor vehicle incidents. *McCormick v Carrier*, 487 Mich 180, 189; 795 NW2d 517 (2010). The Legislature perceived a number of specific problems with the traditional tort system as it related to automobile accidents: "[the contributory negligence liability scheme] denied benefits to a high percentage of motor vehicle accident victims, minor injuries were overcompensated, serious injuries were undercompensated, long payment delays were commonplace, the court system was overburdened, and those with low income and little education suffered discrimination." *Shavers v Attorney General*, 402 Mich 554, 579, 267 NW2d 72 (1978).

In designing the system, the Legislature intended "to provide *individuals injured in motor vehicle accidents* assured, adequate and prompt reparation for certain economic losses at the lowest cost to the individual and the system." *Gooden v Transamerica Ins Corp of America*, 166 Mich App 793, 800, 420 NW2d 877 (1988) (emphasis added); see also *Davey v DAIIE*, 414 Mich 1, 10; 322 NW2d 541 (1982).

Allowing a provider to independently litigate claims against the no-fault carrier does nothing to advance the well-established policy goals of the no-fault act.

To the contrary, in reality the historical record demonstrates that the practice has directly and substantially frustrated these goals.

A. Provider Litigation Places an Additional Burden on the Court System

Prior to the no-fault act, reparations for losses sustained in a motor vehicle accident were generally only available under tort law. Largely because the degree of fault is so often at issue in such claims, many car accidents resulted in litigation wherein the plaintiff was accorded one opportunity to pursue all of his or her damages. Our courts were being overrun by motor vehicle accident tort litigation. The no-fault act was intended to cure this problem by limiting tort liability in exchange for ensuring "victims of motor vehicle accidents assured, adequate, and prompt reparation for certain economic losses." *Shavers v Attorney General*, 402 Mich 554, 579, 267 NW2d 72 (1978); see also *McCormick v Carrier*, 487 Mich 180, 189; 795 NW2d 517, 523 (2010). While the possibility of litigation was by no means eliminated, the goal was to minimize the accidents that resulted in the filing of a lawsuit. Ideally, litigation was only necessary (1) in cases where a third-party tort claim was preserved, (2) in those rare cases when a dispute arose concerning first-party no-fault coverage.

Quite ironically, thirty-five years after its adoption, the volume and frequency of automobile litigation appears to have metastasized far beyond what could be imaginable even under the traditional tort system. Under the tort system, a high percentage of automobile accidents resulted in one lawsuit. Today, a lower yet significant percentage of automobile accidents result in five or more lawsuits,

with many resulting in repeated litigation years after the accident. *MDTC* suggests that the impetus for this relatively new burden on our judicial system is not the nature of lifetime PIP benefits; but, is rather the continued adherence by the lower courts to the notion that each one of a person's healthcare providers has an independent claim that it can bring separate and apart from the civil action brought by the injured person.

At the time that the Court of Appeals issued its opinion in this case in October of 2015, the problem of duplicative litigation had already become a pandemic with substantial effect on both the circuit and district courts of this state.[14] It is not uncommon for one injury to spawn five or six separate lawsuits in as many different venues. The following examples illustrate the duplicative litigation and needless waste of judicial resources occurring in the name of "healthcare providers' rights." While these cases do not represent all provider litigation, these examples are by no means anomalies and are representative of a substantial portion of the type of first party litigation being presented to the trial courts on a regular basis.

[14] See Brief of Amicus Curiae Auto Club Insurance Association.

1. The Case of David Smith – *One Person, One Accident, Five Separate Civil Actions in Four Separate Venues*

David Smith alleged that he was injured in a car accident on July 11, 2015 in the City of Detroit.[15] Because no insurance policy was applicable to him at the time of the accident, he sought PIP coverage through the assigned claims plan, which assigned his claim to State Farm. Smith filed a civil action seeking PIP benefits from State Farm on October 28, 2015, claiming, among other damages, benefits for "medical and/or hospital expenses and/or medical supplies and attention."[16]

On February 8, 2016, Silver Pine Imaging, LLC, filed a separate lawsuit against State Farm in the 15th District Court (City of Ann Arbor) through its own counsel.[17] Despite the pendency of Smith's action, Silver Pine indicated that "there was no other pending or resolved civil action arising out of the transaction or occurrence in the complaint."[18] Silver Pine's complaint sought PIP benefits in the amount of $21,000.00 on behalf of David Smith for the four MRIs it said to have performed for him on August 10, 2015.[19]

Next, on May 2, 2016, Total Toxicology Labs, Inc filed a separate lawsuit, through its own counsel, in the 36th District Court (City of Detroit) against State

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[15] *Amicus* MDTC Appx., p. 3. The complaint that was filed on his behalf actually alleges injuries sustained by a Darrel Vance, which appears to be a typographical error.

[16] *Amicus* MDTC Appx., p. 5.

[17] *Amicus* MDTC Appx., p. 7.

[18] *Amicus* MDTC Appx., pp. 7 & 8.

[19] *Amicus* MDTC Appx., pp. 10-12.

Farm seeking $1,870.89 for the "medical related services" it "provided…to David Smith on July 28, 2015 for the injuries he sustained" in the July 11, 2015 motor vehicle accident.[20] Again, the plaintiff's attorney affirmed that there was no other pending or resolved civil action arising out of the same transaction or occurrence alleged in the complaint.[21]

Then, on July 1, 2016, Synergy Spine and Orthopedic Surgery Center, LLC filed a new civil action against State Farm in the Washtenaw Circuit Court.[22] In this fourth civil action, Synergy Spine alleged to be entitled to $38,783.99 for "medical services rendered" for David Smith for injuries associated with the July 11, 2015 accident. Coincidently, Synergy was represented by the same attorney representing Silver Pine Imaging, LLC in the pending 15th District Court action. Despite this, that attorney certified, again, that there was no other pending or resolved civil action arising out of the same transaction or occurrence alleged in the complaint. [23]

Finally, on July 12, 2016, There and Back Transportation, LLC filed a fifth civil action against State Farm in the 36th District Court, through separate counsel.[24] That complaint alleges that the plaintiff is entitled to $9,159.00 for

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[20] *Amicus* MDTC Appx., pp. 13-16.

[21] *Amicus* MDTC Appx., p. 13.

[22] *Amicus* MDTC Appx., pp. 17-20.

[23] *Amicus* MDTC Appx., p. 17-18.

[24] *Amicus* MDTC Appx., p. 24.

"reasonable and necessary transportation services for medical treatment to David Smith due to injuries sustained in a motor vehicle accident occurring on or about July 11, 2015."[25] As with the previous four cases, the plaintiff and its attorney indicate that they are unaware of any prior civil litigation.[26]

2. Kenya Jackie Huston – *One Person, One Accident, Four Separate Civil Actions in Three Distinct Venues*

Kenya Huston alleges that she was hit by a car while crossing the street on April 24, 2015 in the City of Detroit.[27] On April 4, 2016, she filed a civil action in the Wayne Circuit Court alleging negligence against the owner and driver of the vehicle that she alleges struck her, as well as claiming that Farmers Insurance, the insurance carrier assigned to her claim under the assigned claims plan, failed to pay PIP benefits.[28] Among the other claims, Huston alleged that Farmers was obligated to pay to her benefits for "medical and/or hospital expenses and/or medical supplies and attention." [29]

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[25] *Amicus* MDTC Appx., p. 26. The complaint does not reference the underlying medical treatment precipitating the need for the transportation services the plaintiff alleges to have provided. It would appear fair to assume that the transportation services are associated with treatment at issue in one of the other three provider lawsuits filed against State Farm.

[26] It is this writer's understanding that at the time of this writing, all five cases remain pending as separate civil actions in various stages of litigation.

[27] *Amicus* MDTC Appx., p. 31.

[28] *Amicus* MDTC Appx., p. 29.

[29] *Amicus* MDTC Appx., p. 35.

A little over three weeks later, Get Well Medical Transport Co filed a separate civil action in the 19th District Court (Dearborn) against Farmers through separate counsel.[30] Get Well's legal theory was rather specific and worth noting:

> 5. On APRIL 24, 2015, as a result of a motor vehicle accident, KENYA HUSTON sustained accidental bodily injuries within the meaning of Defendant's policy and the statutory provisions of MCL 500.3105, and incurred reasonable and necessary expenses for care, recovery, or rehabilitation including allowable expenses per MCL 500.3107(1)(a) consisting of expenses incurred by Plaintiff GET WELL MEDICAL TRANSPORT CO. for transportation of the subject patient to and from medical facilities.
>
> 6. Pursuant to MCL 500.3112, personal protection insurance benefits are payable for bills incurred for reasonable charges for products, services and accommodations for the benefit of Defendant's insured, KENYA HUSTON's care, recovery, or rehabilitation, and said benefits are payable to Plaintiff.
>
> 7. Pursuant to MCL 500.3101 et seq., including MCL 500.3107(1)(a), and MCL 500.3112, Plaintiff GET WELL MEDICAL TRANSPORT CO., a provider who provided services to Defendant's insured, KENYA HUSTON, is entitled to enforce Defendant's legal obligation to pay allowable expenses per MCL 500.3101 et seq., specifically MCL 500.3107(1)(a).
>
> 8. Pursuant to MCL 500.3101, et seq., Plaintiff has a right of direct action against Defendant for unpaid allowable expenses per MCL 500.3107(1)(a).
>
> 9. Defendant has refused to pay Plaintiff and/or has unreasonably delayed in making proper payments to Plaintiff of personal protection insurance benefits in accordance with the applicable no-fault and contract provisions. [*Amicus* MDTC Appx., pp. 39-40.]

[30] *Amicus* MDTC Appx., p. 37.

Get Well sought $4,400 for "expenses incurred by Plaintiff Get Well Medical Transport Co. for transportation of the subject patient to and from medical facilities." Unlike the prior examples, this plaintiff and its attorney were aware that Huston filed her own separate civil action in the Wayne Circuit Court just three weeks earlier.[31] Despite disclosing the prior action, both the plaintiff and the District Court proceeded completely unfazed by the prior pending litigation.

Then, on May 25, 2016, one month after Get Well filed its civil action, Affiliated Diagnostics of Oakland LLC filed its own lawsuit against Farmers in the 44th District Court (Royal Oak).[32] Affiliated alleged that Farmers was in "breach of its contractual obligation to make payment for the medical expenses incurred by Plaintiff." Affiliated sought $15,150.00 for three MRIs it performed on Huston shortly after the accident. Unlike Get Well, Affiliated denied knowledge of any other related civil action.[33]

Finally, on July 20, 2016, Vital Community Care, Inc filed its own action against Farmers, through separate counsel, in the 19th District Court.[34] Vital Community Care alleged that it provided Kenya Huston "with medical products, services, or accommodations…for injuries arising out of the [April 24, 2015] motor

[31] *Amicus* MDTC Appx., pp. 37-38.

[32] *Amicus* MDTC Appx., p. 41.

[33] *Amicus* MDTC Appx., p. 42.

[34] *Amicus* MDTC Appx., p. 51.

vehicle accident."[35] In count one of its complaint, the plaintiff purported to plead a cause of action it labeled "Violation of Statutory Duty," for which it alleged that it was a "claimant" within the meaning of MCL 500.3112" and that it was "entitled to pursue a direct cause of action for payment of the *medical treatment* pursuant to MCL 500.3112 et. seq."[36] The plaintiff also pled a separate count, which it labeled, "Breach of Contract – Third Party Beneficiary" under which it alleged to be "an intended third-party beneficiary of the aforementioned insurance contracts [issued by Farmers and providing coverage to Kenya Huston]."[37] This plaintiff did not disclose or reference any of the prior pending litigation.[38]

3. The Solution to these Problems Requires the Rejection of "Provider Litigation"

In both examples, the healthcare providers are actively litigating claims for which previous lawsuits were filed and pending. The litigation is completely duplicative inasmuch as the injured person seeks the same exact benefits that are being pursued in the second provider lawsuits.[39] Scenarios akin to these are not unique by any means and have become the norm in many of this state's trial courts.

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[35] *Amicus* MDTC Appx., p. 53.

[36] *Amicus* MDTC Appx., p. 55.

[37] *Amicus* MDTC Appx., p. 55.

[38] *Amicus* MDTC Appx., pp. 51-52.

[39] While a handful of legal devices would arguably preclude this duplicative litigation, as a practical matter most of the courts are of the belief that the *Covenant* decision expressly authorizes this type of duplicative litigation, to the extent that many defendants have simply accepted a reality that requires parallel and duplicative litigation.

The impetus for this waste of judicial resources and unnecessary burden on our courts is the continued propitiation of the myth that a provider has an independent and direct cause of action it is entitled to pursue under all circumstances.

Certainly, the no-fault act requires an injured person to act diligently to preserve his or her rights. [40] And, under certain circumstances, the failure of an insured to act diligently can impact a provider's economic interests. But, neither of the underlying plaintiffs here were sleeping on their rights. In fact, after confirming that its patient preserved her rights in filing a civil action against the insurer, the provider still filed its own duplicative action.

The solution is found in the traditional application of contract law principles which otherwise control a no-fault insurance dispute. The provider's remedy is the pursuit of its patient who is necessarily legally obligated for the payment of charges for the services performed. The possibility of duplicative litigation is almost totally eradicated if the provider's remedy were limited to filing suit against its patient.[41]

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[40] See, e.g., MCL 500.3145, limiting the recovery of benefits to those incurred no more than one year back from the filing of a civil action.

[41] Because venue for such a lawsuit would only be appropriate where the patient/defendant resides, even the possibility of inadvertent duplicative lawsuits would be greatly minimized. MCL 600.1621. A provider looking to enforce its rights could check if a prior action has been filed against the patient in either the district or circuit court where the patient resides. In the current "provider v insurer" practice, the provider is listed as the plaintiff with a parenthetical to denote the patient. Because most trial court dockets do not include the parenthetical reference, it is currently difficult to search trial court dockets to determine if any actions have been filed associated with a patient.

The provider is sufficiently protected by way of the incentive the injured person has to fully pursue its rights against the insurer.[42]

B. Provider Litigation Increases Fraud, Waste, and Abuse of the Michigan No-Fault Insurance System

As plaintiff points out, an important policy goal behind the no-fault act includes the "prompt payment to the insured" for certain economic losses.[43] An equally important and settled policy aim of the act is the containment of the costs of health care. As this Court observed:

> It is to be recalled that the public policy of this state is that "the existence of no-fault insurance shall not increase the cost of health care." *Dean v Auto Club Ins Ass'n*, 139 Mich App 266, 274; 362 NW2d 247 (1984). Indeed, "[t]he no-fault act was as concerned with the rising cost of health care as it was with providing an efficient system of automobile insurance." *Id.* at 273, 362 NW2d 247. To that end, the plain and ordinary language of § 3107 requiring no-fault insurance carriers to pay no more than reasonable medical expenses, clearly evinces the Legislature's intent to "place a check on health care providers who have 'no incentive to keep the doctor bill at a minimum.' " *Dean*, *supra* at 273, 362 NW2d 247.

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[42] Arguably, other legal devices, such as an assignment of rights, could be used to transfer the insured's rights to the healthcare provider so that it could pursue those rights in its own stead. However, unlike the scheme of concurrent rights that plaintiff advocates for, the application of those devices vest one clear party with the right to pursue the action, preventing multiple parties from pursuing the same rights. See, e.g., MCR 2.116(C)(7) (recognizing assignment as a bar to the pursuit of a civil action).

[43] *Ross v Auto Club Group*, 481 Mich 1, 11, 748 NW2d 552 (2008). *MDTC* maintains that a provider's right to directly and independently pursue a cause of action neither advances nor frustrates this goal, as discussed below.

Despite this policy, the lure of unlimited benefits for medical care coupled with the absence of real cost controls often works against this aim.[44] While many of those obstacles are inherent in the design of some of the no-fault components, MDTC posits that "provider litigation" has significantly contributed to the increasing healthcare costs under the system, and, ultimately, the spiraling increase in insurance premiums.

All too often in provider litigation, the provider attempts to dispose of all involvement by the injured person, and in many cases, by the time that the dispute arises, the insured/patient cannot be located. Without access to the injured person, the insurer is handicapped in its ability to determine an insured's physical condition and whether the claimed treatment is reasonably necessary. Recognizing the importance that only legitimate claims be paid,[45] the Legislature expressly mandated that, when reasonably requested by the insurer, insureds must submit to mental or physical examinations. MCL 500.3151. To enforce the requirement, the Legislature gave broad authority to courts to order a remedy against a "disobedient claimant," including the forfeiture of the right to PIP benefits. MCL 500.3153. However, as was demonstrated in *Chiropractors Rehab Group, PC v State Farm Mut Auto Ins Co*, 313 Mich App 113, 137; 881 NW2d 120, 133 (2015), the

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[44] Tennyson, Sharon, Ph.D, *The High Costs of Michigan's No-Fault Auto Insurance Causes and Implications for Reform,* (Prepared for the Michigan Chamber of Commerce, April 22, 2011).

[45] See *AOPP, supra* at 378 ("[i]t is clear that the Legislature did not intend for no-fault insurers to pay all claims submitted without reviewing the claims for lack of coverage, excessiveness, or fraud").

enforcement of this provision is difficult, if not impossible, when the plaintiff is not the "disobedient person," but rather, the "disobedient person's healthcare provider."[46]

Allowing PIP litigation to proceed without the injured person creates potential for collusion and other wrongful conduct for which the injured person can be shielded in the name of the "provider's rights." MDTC submits that this is the same risk the Legislature was attempting to avoid when including the so-called "name and retain" provision in the Michigan Dram Shop Liability Act. Under MCL 436.1801(5), a plaintiff may not proceed with a dram shop action unless the individual intoxicated tortfeasor is named as a defendant and retained in the civil litigation:

> An action under this section against a retail licensee shall not be commenced unless the minor or the alleged intoxicated person is a named defendant in the action and is retained in the action until the litigation is concluded by trial or settlement. [MCL 436.1801(5).]

This Court explained the purpose and policy behind this rule:

> One of the ways the "name and retain" provision prevents fraud and collusion is by ensuring that the defendant will have a direct financial stake in personally testifying, examining witnesses, and arguing that he did not act in a negligent manner. Once the defendant's liability is fixed and limited, he has no incentive to produce witnesses or testimony tending to prove that he was not "visibly intoxicated" on the date in question. The dramshop defendant may have much more difficulty in identifying,

[46] Presumably, a defendant insurer in that predicament would have to pursue the judicial remedy provided for in MCL 500.3153 by way of a separate declaratory judgment action against the injured person: further litigation that would be unnecessary if the injured person was already before the court.

> locating, and obtaining favorable testimony from the defendant's friends or acquaintances who observed him at relevant times. Retaining the allegedly intoxicated person as a nominal defendant, with instructions not to "hurt or help either side" is insufficient to satisfy the name and retain provision. [*Putney v Haskins*, 414 Mich 181; 324 NW2d 729 (1982).]

The same policy concerns favor litigating no-fault insurance disputes with the injured person retained as a party to the action, at least in some capacity. In light of the potential problems and frustrations caused by litigating a no-fault claim without the injured person having been joined as a necessary party to the litigation, a rejection of provider litigation serves the interest of preventing waste, fraud and abuse of the system.[47]

C. The Elimination of Provider Litigation will not Unduly Burden Healthcare Providers

There is no denying the economic reality on which plaintiff's arguments are grounded. Yes, plaintiff has a "claim" against the injured person for its charges; but, as a practical matter, there is little likelihood that such a claim will result in actual economic remuneration. Plaintiff, like any rational plaintiff, would certainly choose to assert its claim against the proverbial "deep pocket."

In arguing for independent and direct rights against the no-fault carrier, however, plaintiff has gotten ahead of itself. Plaintiffs are not the only reasonable

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[47] During the course of oral argument on the matter of *Bronson Methodist Hosp v MI Assigned Claims Facility* (Docket No. 151343) on October 6, 2016, the Court and the parties discussed the role and duties of healthcare providers seeking assignment of a claim on behalf of its patient without any real knowledge as to the patient's eligibility for benefits under the plan. The discussion recognized the problem inherent when a provider who lacks knowledge of a person's eligibility attempts to pursue benefits under the assigned claims plan.

and rational litigants. Certainly, if providers were to initiate litigation against their patients, or even as much as pursue informal collections against them, it can be presumed that the patient will take steps to invoke the "insurance coverage" that is otherwise available for his or her benefit.

Discontinuing provider litigation does not work practical hardship on the plaintiff provider. The provider can still pursue litigation to enforce its right to be paid for the services it performed.[48] Recognizing that the provider's claims run solely to its patient will not undermine any of the policy goals of the no-fault act or leave healthcare providers fitting the bill for services performed for automobile accident victims. Instead, it will reduce litigation and dissuade healthcare providers from performing treatment that is not necessary, thereby furthering important policy goals of the no-fault act. As discussed above, other jurisdictions considering the question have determined that, as a legal matter, the provider cannot proceed independently of the insured. Despite this, there is no suggestion that healthcare providers have been constrained and prevented from earning an honest income for honest work.

In light of the burden imposed on the judicial system by duplicative and unnecessary lawsuits, as well as the sufficiency of a provider's traditional legal remedies against its patient, MDTC urges this Court to reject plaintiff's proposition

[48] During the October 6, 2016 oral argument in *Bronson Methodist Hosp, supra,* Justice Viviano asked Bronson's counsel why it could not sue the patient. With little explanation, counsel cited the one-year back rule as the obstacle to pursuing that course. While the short timeframes present a challenge in certain cases, that would not otherwise appear to be a basis to categorically reject that alternative course as ineffective.

that a healthcare provider has a direct and independent legal right of action against its patient's insurer.

III. AN ADJUDICATION UNDER MCL 500.3112 IS ONLY NECESSARY TO ESTABLISH THAT "PAYMENT" BY ITSELF DISCHARGES AN INSURER'S OBLIGATION

The rule that MDTC advocates for is the broad recognition that only the insured or "injured person" has a direct cause of action against the insurer. The adoption of that broad rule would eliminate "doubt about the proper person to receive the benefits or the proper apportionment among the persons," as between providers and the injured person, thereby relegating the role of an adjudication to its intended function in allocating survivor's loss benefits.

If, however, this Court concludes that a provider can proceed directly and independent from the injured person, the question remains concerning the necessity of MCL 500.3112 in providing finality and confirming the discharge of an insurer's obligation. The answer to that question is rather clear when the erroneous construction of the statutory provision is examined and repaired.

MCL 500.3112 is rather limited in its scope. By its plain language, it governs when "payment" will not otherwise discharge an insurer's liability:

> ***Payment*** by an insurer in good faith of personal protection insurance benefits, to or for the benefit of a person who it believes is entitled to the benefits, discharges the insurer's liability to the extent of the payments unless the insurer has been notified in writing of the claim of some other person. [MCL 500.3112 (emphasis added).]

Nothing in that section or anywhere else in the no-fault act, though, suggests that "payment" is the exclusive way an insurer can discharge its obligation. Generally,

all legal obligations can be discharged through any number of devices including, release, prior judgment, immunity granted by law, statute of limitations, or assignment.[49] MCL 500.3112 only modifies and restricts the circumstances under which "payment" will work a discharge, and the language of that section does nothing that would affect the operation of any of those other devices. The Court of Appeals panel, both figuratively and literally, "read" the term "release" into MCL 500.3112, where it is not otherwise found. In paraphrasing the effect of MCL 500.3112 the panel said:

> When the relevant services were rendered and the insurer received notice of the provider's claim *before* the settlement occurred, the payment **and release** do not extinguish the provider's rights. [*Covenant Med Ctr, Inc, supra,* at 54 (ital. in the original, other emphasis added).]

When the statute is applied without the addition of "and release," it follows that the only time an adjudication is required is when an insurer is relying on payment alone to discharge his duty to pay benefits for which it has been notified of the claim of another person. Because MCL 500.3112 does not preserve claims that would otherwise be discharged by release, waiver, res judicata, or other device, an adjudication is not required in those circumstances as those devices operate to discharge the obligations to which they are subject.

In this case, State Farm does not rely on its payment alone, but rather the express release signed by the insured. Assuming that the release is otherwise valid

[49] See MCR 2.116(C)(7).

and enforceable, it will discharge State Farm's obligation, notwithstanding MCL 500.3112.

While this proper construction would solve the problem in claims that are litigated, where some other device besides mere "payment" will generally operate to create a discharge, a vast majority of PIP claims are resolved by way of payment alone. Even if this Court were to correct the error in how the Court of Appeals construed this statute, the remaining conclusions would require an adjudication for finality every time an insurer wishes to pay a simple bill. For that reason, merely repairing the misconstruction of the statute does not solve the problem presented by the ruling. The narrow fix does not begin to patch the problem in our no-fault system and the burden on our trial courts introduced by the recent advent of "provider litigation." Therefore, the MDTC asks this Court to choose a broad rule precluding direct provider litigation altogether, for all of the reasons previously discussed.

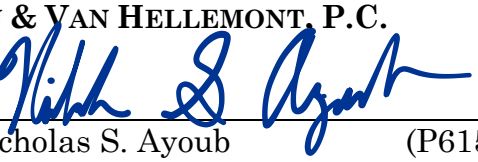
CONCLUSION AND RELIEF REQUESTED

For these reasons, and for the reasons set forth by State Farm, MDTC requests that this Court reverse the Court of Appeals and hold that a healthcare provider does not have an independent direct right of action against its patient's no-fault insurer.

Respectfully submitted,

HEWSON & VAN HELLEMONT, P.C.

Dated: October 6, 2016

By 

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STATE OF MICHIGAN

IN THE SUPREME COURT

COVENANT MEDICAL CENTER, Plaintiff-Appellee, v STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY, a Michigan insurance corporation, Defendant-Appellant.	Supreme Court No. 152758 Court of Appeals No. 322108 Saginaw Circuit Court No. 13-020416-NF

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PROOF OF SERVICE

Nicholas S. Ayoub states that on October 6, 2016, he caused to have served a copy of Michigan Defense Trial Counsel's *Amicus Curiae* Brief upon the attorneys of record via the Court's e-filing system and via first-class mail.

HEWSON & VAN HELLEMONT, P.C.

Dated: October 6, 2016

By _____
Nicholas S. Ayoub (P61545)